



Short communication

Prevalence and correlates of electroconvulsive therapy delivery in 1001 obsessive-compulsive disorder outpatients



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ABSTRACT

Individuals with obsessive-compulsive disorder (OCD) who sought treatment in seven different specialized centers (n=1001) were evaluated with a structured assessment battery. Thirteen OCD patients (1.3% of the sample) reported having been treated with electroconvulsive therapy (ECT) in the past. They were older and exhibited higher global severity of OCD symptoms, but were less likely to display symmetry/ordering and contamination/washing symptoms. They also had greater suicidality and increased rates of psychosis. Finally, OCD patients exposed to ECT were more frequently treated with antipsychotics, although they did not differ in terms of responses to adequate trials with serotonin reuptake inhibitors.

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1. Introduction

There is an extensive list of neuropsychiatric conditions for which electroconvulsive therapy (ECT) is considered to be ineffective, including personality, somatoform, and obsessive-compulsive disorders (OCD) (Fink, 2008). Nevertheless, a recent review found that OCD patients continue to receive ECT for different reasons, including life threatening obsessive-compulsive symptoms, severe comorbidities, and treatment resistance, among other factors (Fontenelle et al., 2015). For instance, an OCD patient had received ECT for “walking compulsively on highways, often 50–60 km daily” (Nilsson and Ekselius, 2009). Similarly, major depression, increased suicidality, catatonia, mania, psychosis and agitation were often reported to be indications for ECT in OCD patients, as were previous positive responses to ECT and drug related side effects (Fontenelle et al., 2015). Yet, some of these scenarios (e.g. comorbid affective disorders and increased suicidality) are not uncommon in treatment seeking OCD samples (Torres

et al., 2011) and may be equally reported in patients who have not been exposed to ECT during their lifetimes.

Given these superficial similarities between OCD patients who have and those who haven't been previously treated with ECT, it is important to clarify whether and how these two groups differ from each other. It is possible that features embedded within OCD phenotype (e.g. symptom dimensions) contribute to the patients' “odds” of being more “aggressively” treated. For instance, while OCD symptoms' dimensions associated with positive responses to conventional treatment may be less frequently reported in OCD patients treated with ECT, the presence of “violent and blasphemous” symptoms may be perceived as being more “risky” by patients and clinicians (Simonds and Thorpe, 2003). In this study, we aimed to: (i) describe the rates of past ECT use in a treatment seeking sample of 1001 OCD patients, and: (ii) investigate how patients treated with ECT differ from OCD patients who were not treated with ECT. By doing so, we expect to understand why clinicians continue to recommend and administer ECT for OCD patients despite the fact that ECT is not listed as a valid therapeutic alternative in many important treatment algorithms (e.g. Stein et al., 2012).

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2. Methods

Individuals with OCD who sought treatment in seven different specialized centers across five different Brazilian states were evaluated with an assessment package that included, among other information, relevant socio-demographic data, lifetime presence and severity ever of different OCD symptom dimensions (using the Dimensional Yale-Brown Obsessive-Compulsive Scale), severity of depression and anxiety, comorbidity rates using the Structured Clinical Interview for DSM-IV Psychiatric Disorders (SCID), and past treatment history (Miguel et al., 2008). Assessment of previous ECT treatments was standardized as “Have you ever been treated with ECT?”.

All subjects signed an informed consent after an explanation of the procedures involved was given. The local institutional review boards approved this project, which was in full accordance with the declaration of Helsinki. Given the low numbers, we have performed Fisher's exact tests to compare frequencies of categorical variables and Mann-Whitney *U* test's to compare continuous variables between patients who were vs. who were not treated with ECT. The adopted level of significance was 0.05. No correction for multiple statistical comparisons was applied, considering the preliminary and exploratory nature of this investigation (Bender and Lange, 2001).

3. Results

Only 13 OCD patients (1.3% of the total sample) reported being treated with ECT during their lifetimes. They were compared to OCD patients who did not have a history of being treated with ECT in terms of socio-demographic features, symptom profiles, suicidality, comorbidity rates and treatment features (Table 1). Patients with OCD who were treated with ECT were generally older and had higher global severity levels during their worst illness period(s), but were less likely to exhibit symmetry/ordering and contamination/washing symptoms. They also had increased suicidality levels (including death wishes, suicidal thoughts and suicide plans) and greater rates of psychosis, which were particularly higher when both depression/mania associated psychosis and other psychotic disorders were collapsed as a single variable. In addition, OCD patients treated with ECT were more frequently treated with adequate trials of antipsychotics, although differences in terms of number of adequate serotonin-reuptake inhibitors (SRI) treatments failed to reach significance. In fact, rates of response to adequate SRI trials did not differ between the groups.

4. Discussion

Our findings indicate that only a small proportion of OCD outpatients (1.3%) had been treated with ECT. Importantly, these findings replicated the results of a previous study in which only 1.4% of OCD patients followed-up for up to 15 years received ECT¹ (Lins-Martins et al., 2015). Although we were unable to locate additional studies investigating the frequency of ECT use in other specialized OCD services, we believe these rates look reassuringly low compared to the ones that would be expected in affective and/or psychotic disorders outpatient clinics. The consistency of these numbers across independent samples is also noteworthy, considering that ECT utilization rates, practices and parameters vary greatly throughout continents, countries, or even regions within the same country (Leiknes et al., 2012), making ECT one of the most erratically used procedures in medicine (Hermann et al., 1995).

We have also found that OCD patients treated with ECT exhibited several distinguishing clinical features, including greater global OCD severity levels in the patients' most severe period,

increased suicidality, and higher rates of psychosis, each already described as independent indications for ECT in OCD patients (Fontenelle et al., 2015). However, these features frequently overlap, and many OCD patients display combinations of more than one indication for ECT (Lins-Martins et al., 2015). The presence of a recognizable pattern of OCD features associated with the administration of ECT coupled with the stability of ECT treatment rates in two independent samples (the other being the one reported by Lins-Martins et al. (2015)) suggest that clinicians agree to a large extent on what constitutes an indication for ECT in OCD.

In terms of OCD symptoms, the contamination/washing and the symmetry/ordering dimensions were less frequently observed among OCD patients who received ECT. This finding is consistent with increased responses of these OCD dimensions to conventional treatments [such as exposure and response prevention, ERP (Abramowitz et al., 2003)]. However, they also suggest that clinicians may perceive contamination/washing and the symmetry/ordering symptoms as being less “risky” (perhaps as more stable or predictable) symptoms, thus not requiring a treatment as incisive as ECT. In support of this view is the fact that the rates of “objective” suicide attempts did not differ between OCD patients treated and not treated with ECT. This finding indicates that the prescription of ECT in OCD may be more closely linked to the “perception” of dangerousness, rather than to any objective evidence of it. Also, consistently with the latter hypothesis, we found a non-statistically significant hint towards a greater representation of sexual/religious symptoms as the “worst” symptoms reported by ECT-treated OCD patients, which we will discuss below.

Typically, OCD patients with sexual/religious symptoms have “phobia of impulses”, i.e. fears of displaying unwanted and unacceptable behaviors as key ingredients to their symptoms. “Phobia of impulses” is also prevalent in patients with aggressive thoughts, which frequently load on the same factor as sexual/religious symptoms (Stewart et al., 2008), do not adhere to exposure and response prevention sessions (Santana et al., 2013) and are more often prescribed benzodiazepines (Starcevic et al., 2016). Sexual/religious symptoms have also been found to be marginally more frequent in OCD patients who were resistant to ERP (Rufner et al., 2006) as well as significantly more frequent in OCD patients who were refractory to both ERP and pharmacotherapy (Ferrao et al., 2006).

OCD patients treated with ECT were typically more often prescribed an adequate trial of antipsychotics, although only marginally more likely to be managed with adequate trials of SRIs. Perhaps the fact that ECT patients were more psychotic and suicidal, in association with a clinician's fear of aggravating psychosis with SRIs, may be at the root of this finding, thus hindering OCD patients from being more frequently exposed to adequate trials with SRIs. Nevertheless, the fact that rates of response to pharmacotherapy did not differ between ECT vs. non-ECT OCD patients suggest that, in our sample, features other than treatment resistance may explain why patients with OCD had been treated with ECT. Since these OCD patients reported ECT treatments that were often performed before they were seen in our OCD clinics, these results could well reflect some degree with unfamiliarity with recognized anti-OCD treatments by clinicians who have treated these patients in the past.

Our study has a number of drawbacks. For instance, most reports of previous treatment histories did not entail a cross-referencing with actual patient records to confirm they have actually happened. Also, we were unable to establish previous responses to ERP, since the variable “history of psychotherapy” could be anything from ineffective talk therapy to evidence-based ERP. Most importantly, however, was the difficulty in establishing clear links between specific socio-demographic and clinical features to past use of ECT, which may not have coincided in a particular time

¹ Although 37 patients from the present study were included in the Martins-Lins study, only 1 of them had a history of ECT use, and none of them were prospectively treated with ECT in the later study.

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